Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004426	A. BUILDING: _____ B. WING _____	10/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDISON HOUSE	2244 Q AVE NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: October 9 & 10, 2013 Facility number: 004426 Provider number: N/A AIM Number: N/A Survey team: Leslie Parrett RN TC Angel Tomlinson RN Barbara Gray RN Census bed type: Residential: 25 Total: 25 Census payor type: Other: 25 Total: 25 Residential sample: 5 Addison House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality Review 10/14/13 by Lisa McColly	R 000		